The county-specific data book brought together, under one cover, all of the known health-related state and county data available from standard reports and computer printouts. The Guide attempted to advise the user on the concepts, materials, and methods of community diagnosis. For the first time, the term "community diagnosis" was defined: a means of examining aggregate health and social statistics, ***liberally spiced with the investigator's subjective knowledge of the local situation***, to determine the health needs of the community.

These materials and underlying concepts were presented at a series of six strategically located workshops attended by local health department personnel from across the state. Since that time, selected data in the Health Data Book have been updated annually and the series of workshops conducted biennially. Thus began a biennial process whereby local health departments were asked to "analyze" the county-specific data provided by the state as well as their own local situations and to report back to the state each county's priority health needs.

At the 1987 community diagnosis workshops, statisticians from the state health agency attempted to go a step further in assisting local health departments by presenting the methods and materials of community diagnosis in the form of a "model" diagnosis developed for one county. The results were encouraging; at least some counties were able to examine their data and local situations and to produce fairly comprehensive reports of health-related needs in their counties. Other counties, however, still did not have a toe-hold on how to examine and assess their data.

In early 1989, the state health agency conducted a sample survey of participants in the 1987 workshops to determine how best to meet their future needs in the matter of community diagnosis. The result was a cry for help in the organization and structure of the data analysis. Thus, in 1989, the state prepared a new Health Data Book for each county and wrote an all-new "Guide for a Community Diagnosis" (2). The Guide included worksheets for use in the analysis of data, questions to answer about community perceptions and behavior, and pointers on program evaluation.

THE 1991-92 APPROACH

Based on participants' comments and responses to a sample survey conducted in 1990, the "cookbook" approach used in the 1989 workshops was deemed highly successful, so the same approach was planned for 1991. However, past results and several new national and state initiatives suggested the need to review and define the counties' reporting requirements.

In previous cycles of Community Diagnosis, the state health agency had requested the reporting of "health needs" but without defining the term. The result had been a mishmash of problem and need statements which were sometimes difficult to categorize, so some sort of standardization was deemed essential. Meanwhile, these initiatives and their protocols also needed to be considered:

- *Healthy People 2000* (national objectives focusing on the health problems of people)
- *Healthy Communities 2000: Model Standards* (community objectives to address the national objectives)
- *Assessment Protocol for Excellence in Public Health* (APEX), Part II (guide to identifying priority community health problems and programmatic objectives, in a manner consistent with Healthy People and Healthy Communities)
- House Bill 183, Section 1, Subsections (a)(2) and (a)(4) which address the state health agency's role in assessing health status and health needs in every county and in monitoring and evaluating local achievement of health outcome objectives.

In order to standardize reporting and to be responsive to the above, the Community Diagnosis protocol now requests local reporting of two types of community health problems, defined as follows:

1. **Health Status Problem:** A situation or condition of people which is considered undesirable, is likely to exist in the future, and is measured as death, disease or disability (APEX).

   A health problem reported in this category ***must be measurable*** at the county level. It may be a leading cause of death or of premature mortality, a leading cause of hospitalization, a leading communicable disease, or another unhealthy condition of people for which there are quantified data. Examples are infant mortality, cancer, heart disease, injuries, AIDS, gonorrhea, measles, substantiated child abuse/neglect, etc. These problems may identify particular subpopulations at risk, e.g., homicide among nonwhite males.